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Letter to the Editor:

The Value of Value-Based Purchasing

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Letter to the Editor:
The Value of Value-Based Purchasing

Dear Dr. Nash,

I very much enjoyed your comments on Value-Based Purchasing in the March 2005 Health Policy Newsletter. I would add yet another challenge: having realistic expectations about what pay for performance (PFP) systems can accomplish. For example, almost by definition, PFP will not work with patients who are so non-compliant that they do not even see the physician. I would put it in the context of Wagner's Chronic Care Model. PFP is part of making the physician/healthcare team activated and informed, but there has to be work from the patient side. Non-compliant patients may best be handled by case management, especially for those patients expected to have complications.

This is the intersection of PFP, predictive modeling, and case/disease management. This intersection is going to be a fruitful area. I've been thinking about how to link them. My organization, the Rochester (NY) Individual Practice Association (RIPA) and our insurance partner, Excellus BlueCross BlueShield Rochester Region, have had an individual physician PFP system for four years. As a result of our Robert Wood Johnson Rewarding Results grant, we now distribute with our profiles a registry of patients with diabetes, asthma, and CAD. The year-end adherence score for each primary care physicians' patients becomes part of their pay for performance. Imagine if we added a predictive modeling score to each chronic disease patient. We could profile physicians on whether they interacted with case/disease management, and we could pay them more for having the higher predicted cost patients. Those two modifications could help solve some of the challenges you pose. They would help decrease motivation to cherry pick the patients (maybe I should say, "help maintain motivation to see the most difficult patients").

We are on the way to making these improvements. We already add points if physicians get their high complexity asthmatics to case managers. At the end of this year we will remove from scoring any chronic disease patient who has not seen a primary care physician in 2005.

I agree with you that PFP can increase both quality and value. We recently published a paper on improving sinusitis care. [1] Physician profiling with rudimentary PFP was a big factor (at that time we varied the withhold percentages based on their profile score). Our intervention produced a significant shift from broad spectrum to narrow spectrum antibiotics. That has been worth about $1 million/ year in reduced antibiotics costs (internal calculations).

Quality improved and costs went down. As others meet the challenges you have outlined, they should see even better outcomes.

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References

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